

STATE OF ARKANSAS
DEPARTMENT OF INSURANCE
FOREIGN LIFE, ACCIDENT AND HEALTH COMPANIES

IMPORTANT INFORMATION***NEW FORMS WITH CHANGES IN CREDIT SECTION*******

It is necessary to include your 5-digit NAIC number in the spaces provided. Do not use the federal identification number in place of your NAIC number.

If you are expecting a refund, please mark "REFUND DUE" on top of page 1.

You are required to file a copy of: 1) the Jurat's Page (pg 1) 2) Annual Statement Direct Business Page reflecting Arkansas premiums (pg 25) and 3) Schedule T (pg 62) from the annual statement.

GENERAL FILING INFORMATION & CHECKLIST

Completing the return:

The return must be typed or legible print on our forms. No Exceptions. **NO AUTHORITY EXISTS FOR GRANTING ANY EXTENSION OF TIME FOR FILING OR PAYMENT.** Forms print on 8 ½ x 11 sheet of paper.

Sending in the return:

Mail your return and check to:

Arkansas Insurance Department
Attn: Accounting Division
1200 West Third Street
Little Rock, AR 72201-1904

If you overnight your return, use the same address. **Do not put Premium Tax return in annual statement. Mail separately.** Do not include the instructions with your return and remittance.

Contact Information: Phone: 501-371-2605

Website: www.arkansas.gov/insurance/forms

Filing Period:

For calendar year ending 12/31/04 the Annual tax forms, related premium taxes and filing fees are due on or before **March 1, 2005.**

Postmark Dates:

The Arkansas Insurance Department does not accept the postmark date for filing requirements. All tax forms must be received in our department on or before 03/01/05. If your company uses a carrier other than the U.S. Postal Service, the Department must receive the filing on or before 03/01/05. All tax forms are subject to penalty (\$100 a day) in accordance with ACA. 26-57-607.

NOTICE: ACA 23-62-108 HAS BEEN REPEALED. THE DEPARTMENT NO LONGER COLLECTS THE CONSUMER INFORMATION ASSESSMENT FEE.

Corporate Franchise Tax:

Do not include Franchise Tax payments in your premium tax filings. Please make your Franchise Tax payments payable to the State of Arkansas and remit them at the appropriate time to the Office of the Secretary of State, Attention: Ms. Charlotte Martin, 1401 Capital Avenue, Suite 250, Victory Building, Little Rock, AR 72201. Direct all inquiries to the Secretary of State at (501) 682-3409 or email to www.sosweb.state.ar.us

IMPORTANT:

The following form is to be **returned to the address noted on their form** on or before March 1, 2005, do not include with Annual Premium tax filing to the Insurance Department.

- 2004 Mandatory Arkansas Comprehensive Health Insurance Form #CHIP ST.SP (04).
- This form can be downloaded at www.arkansas.gov/insurance/
- Scroll down and click on Arkansas Comprehensive Health Insurance Pool. If you have any questions regarding this form call (501) 370-2659.

ARKANSAS
PREMIUM TAX RETURN INSTRUCTIONS

PLEASE TAKE A MOMENT TO LOOK OVER OUR FORMS. THEY HAVE CHANGED THIS YEAR. NOTE THE CREDITS ARE ALL GROUPED ON PAGE 2 OF OUR FORM AND THE COMPANY FINANCIAL REGULATION FORM IS NO LONGER REQUIRED INFORMATION TO COMPLETE THE TAX FILING.

Instructions for Page 1 of the return.

NAIC Codes

Please enter your 5-digit NAIC Company Code in the spaces provided and complete all lines in the company information section. Complete Column 1 – Arkansas Tax and Column 2 – State of Domicile. Provide the **Correct Tax Rate** for the Domiciliary State.

Section A

Line 1(a) **Life Insurance Direct Written Premiums** – Use amount from Annual Statement, Direct Business page 25 for Arkansas, Line 1, Life Insurance: Column 5-Total. **No deduction from this amount may be made on the Arkansas side (Col 1).**

Line 1(b) – Arkansas tax rate is 2.5%. Multiply Line 1(a) by this rate and enter the result on Line 1(b).

Line 2(a) – **Accident & Health** - Enter amount from Annual Statement, Direct Business page 25 for Arkansas, Line 26(Total), Column 1 in the **Accident and Health Insurance** section of page 25(bottom) less Line 24.1-Federal Employees Health Benefits Program Premium. Line 26 minus Line 24.1; enter result on Line 2(a), Column 1.

Line 2(b) – **Dividends Paid or Credited On Direct Business** – Enter amount from Annual Statement, Direct Business page 25 for Arkansas, Line 26 (Total), Column 3 in Accident and Health Insurance Section (bottom).

Line 2(c) – Subtract Line 2(b) from Line 2(a). Enter result on Line 2(c), Column 1.

Line 2(d) – Multiply Line 2(c) by 2.5% tax rate and enter the result in column 1, Line 2(d).

Line 2(e) – **Additional Taxes and Fees from State of Domicile.** Include any/all fees or taxes that would be required of an insurance company doing business in your state, such as: certifications, reviews, audits, filing of financial statements, publishing, franchise/privilege and etc. Do not include ASSESSMENTS. You **must** attach an explanation with computations. **Use this line for fees not shown in Section B.**

Line 3 – Total premium tax due Line 1(b) plus Line 2(d), enters result on line.

Section B

Line 4(a) – Enter the **annual statement-filing fee** from your state of domicile in Col 2. The Arkansas side is completed. **FOR FEES OTHER THAN SHOWN HERE, LIST IN SECT 2(e).**

Line 4(b) – Enter the **Certificate of Authority/annual renewal fee** from your state of domicile in Col 2. The Arkansas side is completed.

All other fees associated with the filing are to be shown in Section A, 2e.

Line 4(C) - Add together Lines 4a through 4b and enter result here in Col 2.

Section C

Line 5 – **Total of all Premium Taxes and Fees Due** - Add together Lines 3 and 4c and enter result here. Complete BOTH columns, even if NONE or ZERO. **Figure cannot be less than zero.**

Instructions for Page 2 of return

Section D

Using the amount shown on Line 5 in Section C, compare both Column 1 and 2; enter the amount that is greater in this space. This is your tax liability. Note you are not to include fees shown in Section B.

Section E

Line 6– **Guaranty Fund Assessment Credit** as calculated by the Life and Health Guaranty Association. **Each company receiving a credit will receive a credit letter from the Life and Health Guaranty Association stating the amount to be placed on Line 6. If you feel there is an error in this computation, please do not change this amount. You will need to contact the Life and Guaranty Association directly.** They will make all corrections and notify the Arkansas Insurance Department. **Attach form to verify amount taken and enter here.**

Line 7 – **Arkansas Comprehensive Health Insurance Pool (CHIP)** credit Form #CHIP ST.SP (04). You will receive an annual assessment fee payable to the CHIP office if you are a participating insurer in the pool. If you do not receive your CHIP form prior to filing your annual return telling you what your credit is, contact the CHIP office at (501) 370-2659. **Attach form to verify amount taken and enter result here.**

Line 8 – **Affordable Neighborhood Housing Credit** (Act 1331-1997) - Insurers that perform affordable housing assistance activities may take a premium tax credit for up to 30% of the total amount invested and not to exceed \$750,000 in any taxable year. Program must meet standards of and be approved by **Arkansas Development Finance Authority**. **Form must be attached to verify amount taken and enter result here.**

Line 9 – **Low Income Housing Tax Credit** - Insurers are allowed a state income or premium tax credit equal to 20% of the federal low-income housing tax credit not to exceed \$250,000 in any taxable year. The credit is available for insurers that own an interest in a qualified project for which the **Arkansas Development Finance Authority** has issued an eligibility statement. **Form must be attached to verify amount taken and enter result here.**

Line 10 (a) – **Credits for Arkansas Salaries – Life** You must complete the **SCHEDULE IC-PT, page 3** before taking this credit; otherwise it will be disallowed. Multiply the amount on Line 1(b) by 70%, this amount cannot exceed Line 1(b), Page 1, Col 1 and enter the result here.

****Note****The sum of 10 (a) & (b) cannot exceed Line 2 of SCHEDULE IC-PT.

Line 10 (b) – **Credits for Arkansas Salaries – A&H** You must complete the **SCHEDULE IC-PT, page 3** before taking this credit; otherwise it will be disallowed. Multiply the amount on Line 2(d) by 80%, this amount cannot exceed Line 2 (d), Page 1, Col 1 and enter the result here.

Line 11 – **Subtotal** is the sum of the amount in Section D less credits listed in Section E on lines 6,7,8,9,10a and 10b. Enter the result here. **If you only owe for fees, you cannot apply credits against fees.**

Line 12– **County and Regional Industrial Development Corporation Credit** (Act 37 of 1999) – Insurers may take a premium tax credit for investments in a county of regional industrial development firm. The credit is equal to 33.33% of the actual purchase price of stock or units of interest and fees paid (with limitations). The maximum credit in one tax year is 50% of the net premium tax liability. Excess may be carried forward for three years. **Please see Bulletin 1-2005 dated 1/7/2005 that replaces former Bulletin 13-99 for detailed instructions regarding taking this credit.** **Attach documentation to verify amount taken and enter result here.**

Line 13 – **Capitol Development Corporation Tax Credit** §§ 15-4-1026,15-4-1029(f)(1) Person who purchases an equity interest in a capital development company between 2004 through 2013 is entitled to a credit against any state income tax liability or premium tax liability, which may be imposed on the purchaser for any tax year commencing with the tax year, which is two years after the date of the purchase. The credit shall be equal to thirty-three and one-third (33 1/3) of the actual purchase price paid for the equity interest to the company, including any fees or commissions to underwriters or sales agents paid by the company. No fees or commissions in excess of fifteen percent (15%) of the total purchase price may be considered in calculating the amount of the credit. In any one-tax year, the credit shall not exceed fifty percent (50%) of the net state income tax liability or premium tax liability of the taxpayer after all other credits or reductions in tax have been calculated. No credit under this section is allowed for any tax year after December 31, 2019.

Upon dissolution, if the proceeds from the purchase of the equity interest have not been used for the purposes stated in §15-4-1016 or for operation expenses, then each person who previously claimed a tax credit with respect to that purchase, the tax imposed for the year the dissolution occurs shall be increased by the tax credit amount associated with the unused purchase proceeds.

Section F

To derive at your **Net Payment Due**, follow instructions below:

Line 14 – **Total Premium Tax Due** - Enter the amount from above in Sect E, Line 11 less credit on Line 12 and 13, if any.

Line 15 – Enter the amount of **Total Fees** from Page 1, Sect B, Col 1 or Col 2, Line 4c. Remember to base your fees on your choice in Section D- Arkansas / State of Domicile side. Enter the chosen column's fee amount here. DO NOT LEAVE BLANK.

Line 16 - Add the amounts listed on Lines 16a through c and enter result here. Fill in appropriate columns with **pre- payment information** for 1st, 2nd and 3rd quarter payment, if any. Do not include penalty fees, only taxes.

Line 17 – Add Lines 14 through 16 and enter result here. Attach check payable to **State Treasurer of Arkansas** for the amount shown on Line 17. **All overpayments will be refunded after audit.** Be sure to mark **“Refund Due”** on the top of Page 1, if you are expecting a refund this year.

Instructions for Page 3 of return

Section G

Life and/or Health Insurers and Health Maintenance Organization Salary Offset §26-57-604

➡ This was formerly known as **FORM AID AC IC- PT**, it is no longer a separate form but part of LD-T. **This section must be completed in order to take the Salary Credit (Lines 10 a, b), or it will be disallowed.**

Each authorized life or accident & health insurer, including an HMO, may take a credit for **noncommissioned salaries and wages** of the insurer's Arkansas employees as an offset against the 2.5% tax on life and /or accident and health insurance. The offset may not reduce tax due on health premiums by more than 80%, or due on life premiums by more than 70%. The employee must be a non-commissioned hire and have been employed 6 months for the wages to qualify.

Line 1 – Enter the number of **non-commissioned** Arkansas employees that were employed for at least 6 months by your company.

Line 2 – Enter the total of wages and salaries paid to these individuals on this line. Be sure to deduct commissions.

Line 3 – You must list the complete address of all offices in Arkansas. If additional space is needed, please attach a listing to return. **If addresses are not provided, credits are not allowed.**

PENALTY

Any insurer or health maintenance organization that fails to report or pay the tax when due shall be subject to a **penalty of one hundred dollars (\$100) for each day of the delinquency.**

Sending in the return

Mail your return and check along with proper attachments to: Arkansas Insurance Department

Attn: Accounting Division

1200 West Third Street

Little Rock, AR 72201-1904

For other questions or comments:

Phone number: 501-371-2605

Fax number: 501-371-2629

Website: www.arkansas.gov/insurance/forms.html

**ARKANSAS INSURANCE DEPARTMENT****2004 FORM AID AC LD-T**ACCOUNTING DIVISION
1200 WEST THIRD STREET
LITTLE ROCK, AR 72201-1904
PHONE: (501) 371-2605
www.arkansas.gov/insurance/ACCOUNTING DIVISION
DUE MARCH 1, 2005

___ ORIGINAL FILING

___ AMENDED FILING

___ REFUND DUE

**ANNUAL REPORT OF PREMIUMS, TAXES AND FEES OF ALL
LIFE AND ACCIDENT & HEALTH INSURANCE COMPANIES**

STATE OF DOMICILE		NAIC COMPANY CODE (5 digit code)
COMPANY NAME		
MAILING ADDRESS		
CONTACT PERSON		
TELEPHONE NUMBER	EXT	FAX NUMBER
EMAIL ADDRESS		

***The Arkansas tax sections impose 2 1/2% tax on the total direct written premium, less applicable deductions under ACA 26-57-601 et. seq. Considerations received on annuity contracts are not subject to premium taxes.**

Total on Line 1a below must be equal to premium reported on the Annual Statement Schedule T and State Page (pg 25, L 1, Col 5) for Life Insurance.

	Column 1 Arkansas Tax	Column 2 State of Domicile Tax on Arkansas Insurer Tax Rate_____
Direct written premium of said Company in Arkansas for the calendar year ending December 31, 2004		
A. LIFE, ACCIDENT AND HEALTH PREMIUMS		
1. a. Life Insurance Premiums	\$_____	\$_____
b. Tax Thereon at 2.5%	\$_____	\$_____
2. a. Accident & Health Insurance Premiums	\$_____	\$_____
b. Less Dividends Paid or Credited	\$_____	\$_____
c. Net Accident & Health Premiums	\$_____	\$_____
d. Tax Thereon at 2.5%	\$_____	\$_____
e. Additional Taxes/Fees from State of Domicile (Attach Explanation)	<u>\$XXXXXXXXXXXX</u>	\$_____
3. Total Premium Tax Due [Col. 1,1(b), 2(d)][Col. 2, 1(b), 2(d), (e)]	\$_____	\$_____
B. FEES		
4. a. Filing Annual Statement	\$ 50.00	\$_____
b. Certificate of Authority	\$ 100.00	\$_____
c. TOTAL FEES	\$ 150.00	\$_____
C. GRAND TOTAL OF ALL TAXES & FEES		
5. Total Taxes & Fees (A3 + B4c)	\$_____	\$_____

BASED ON SECTION C, LINE 5, MARK THE COLUMN WITH THE GREATER AMOUNT:

COLUMN 1 - ARKANSAS

COLUMN 2 - STATE OF DOMICILE

USING THE AMOUNTS FROM THE COLUMN MARKED ABOVE, COMPLETE THE FOLLOWING BY:
D. Entering the amount here from Section A Line 3

\$_____

E. CREDITS, CANNOT BE TAKEN AGAINST FEES

- | | | |
|--------|--|----------------|
| 6. | Arkansas Guaranty Fund Assessment Credit | \$(_____) |
| 7. | Arkansas Comprehensive Health Ins. Pool (CHIP) Credit | \$(_____) |
| 8. | Affordable Neighborhood Housing Credit | \$(_____) |
| 9. | Low Income Housing Tax Credit | \$(_____) |
| 10. a. | Credit for Arkansas Salaries not to exceed 70% of Line 1b. | \$(_____) |
| 10. b. | Credit for Arkansas Salaries not to exceed 80% of Line 2d. | \$(_____) |
| 11. | SUBTOTAL (D less 6-10) | \$_____ |
| 12. | County and Regional Industrial Development Corp Credit | \$(_____) |
| 13. | Capital Development Corporation Tax Credit | \$(_____) |

F. NET PAYMENT DUE

- | | | |
|-----|---|-----------|
| 14. | Total Premium Tax Due (Figure cannot be less than zero)
(E11 less 12 + 13) | \$_____ |
| 15. | Total amount of Fees from Section B, based on Section D | \$_____ |
| 16. | Deduct Pre-payments, if any, from below and enter here. | \$(_____) |

Quarters	Check #	Amount
16.a. First		
16.b. Second		
16.c. Third		

- | | |
|------------------------------------|---------|
| 17. Net Payment Calendar Year 2004 | \$_____ |
|------------------------------------|---------|
- (CHECK MADE PAYABLE TO THE STATE TREASURER OF ARKANSAS)**

SCHEDULE IC-PT**LIFE AND /OR ACCIDENT AND HEALTH INSURERS AND HEALTH MAINTENANCE
ORGANIZATION SALARY ANNUAL OFFSET**

Each authorized life or accident and health insurer, including an HMO, may take an annual credit for **non-commissioned** salaries and wages of the insurer's Arkansas employees as an offset against the 2.5% direct written tax on life and or accident and health insurance. The offset may not reduce tax due on accident & health premiums by more than 80%; or due on life premiums by more than 70%. The employee must be a non-commissioned hire and have been employed 6 months in Arkansas for the wages to qualify.

The Company reports as follows:

1. Number of non-commissioned Arkansas employees employed for a minimum of six (6) months as of the last day of the calendar year to which this report applies: _____
2. Amount of **non-commissioned** salaries and wages paid to individuals listed in item 1 above:
_____.
3. Complete addresses of Company's Arkansas offices, which are staffed with individuals listed in Item 1.
 - a.
 - b.
 - c.

Attach additional sheets if necessary.

CHECKLIST

Copy of Schedule T of Annual Statement attached?..... ☐ YES ☐ NO
 Copy of AR Direct Business, pg 25 of Annual Statement attached?..... ☐ YES ☐ NO
 Copy of Jurat page from Annual Statement attached?..... ☐ YES ☐ NO
 Completed Schedule ICPT for Salary Credit?..... ☐ YES ☐ NO
 Attached check payable to **State Treasurer of Arkansas**?..... ☐ YES ☐ NO
 Signed and Notarized return?..... ☐ YES ☐ NO

AFFIDAVIT

State of _____ County of _____

Comes _____ and states on oath that he/she is the

_____ of _____
 (Title) (Name of Company)

and that the foregoing statements are true and correct as shown by the records of said Company.

Subscribed and sworn to or affirmed before me, the undersigned Notary Public, on this the _____ day of _____, 20_____

My Commission Expires _____

 NOTARY PUBLIC

FOR Insurance Department Use Only:

Verified by: _____ RT Slip # _____ Check# _____ Amount _____